

Communicable Disease

UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health

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Spring 2000

Summary of West Nile Virus in the United States

In early August 1999, cases of encephalitis of unknown cause occurred in residents of New York City. At the same time, bird die-offs involving large numbers of birds were observed. On September 14, virus isolated from a crow in New York City (NYC) was identified as West Nile virus (WNV). This virus was also determined to be the cause of disease in humans. On October 18, the Centers for Disease Control and Prevention (CDC) confirmed WNV in a horse with signs of encephalitis on Long Island, New York.



During the outbreak, which began in early August and ended in mid-October, 62 humans were clinically ill with WNV encephalitis. Seven died. All of the human cases occurred in NYC, and Nassau and Westchester Counties in New York. In addition, 23 cases of WNV disease were identified in horses in New York state. Mosquitoes, particularly *Culex* species, and many species of wild birds were also found to be carrying WNV. Bird cases have been identified in New Jersey, Connecticut, New York and Maryland. Bird cases were found as far north as Columbia County, New York which lies on the Western border of Massachusetts. No infected mosquitoes, birds, horses, or humans were identified in Massachusetts in 1999.

Sporadic and epidemic WNV infection occurs in Africa, India, Australia, Egypt and the Middle East, and occasionally in Eastern Europe. Until this summer, WNV had never been identified in the Western Hemisphere. It is not known how WNV was introduced into the US. It may have been imported through an infected human, bird or mosquito.

In early 2000, WNV was found by the CDC to have overwintered in mosquitoes, and the virus was detected in a bird from New York. Because of concerns about the ability of WNV to establish itself in the Eastern United States, the CDC is funding state



programs along the East Coast to conduct surveillance for WNV in birds and mosquitoes.

During the spring, summer and fall of 2000, the Massachusetts Department of Public Health (MDPH) will conduct statewide mosquito surveillance for WNV, as well as test wild birds, and suspect human and horse cases. Also, MDPH will be conducting public education campaigns on how to reduce the chances of being bitten by mosquitoes. Health care providers and public health officials can help educate the public about WNV disease and prevention. For a list of prevention measures, look for the West Nile Virus Fact Sheet and the fact sheet on mosquito prevention tips on the MDPH website www.state.ma.us/dph.

For an excellent, detailed, and comprehensive summary of the West Nile Virus outbreak, visit the USDA's Veterinary Services website at www.aphis.usda.gov/vs/ep/WNV/summary.html. Additional information can also be found on the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov.

Eliminating Syphilis

In the new millennium, the United States is faced with a unique opportunity to eliminate syphilis within its borders. Syphilis is easy to detect and cure, given adequate access to services and treatment. In the U.S. as well as in Massachusetts, syphilis is at the lowest rate ever recorded and its occurrence is very localized geographically. Almost 50% of all of the infectious syphilis reported in the United States in 1998 came from less than one percent (28) of 3200 counties. Where syphilis does persist, it disproportionately affects Americans living in poverty.

Syphilis elimination is not only technically feasible, but can have far-reaching public health implications by removing consequences, such as increased likelihood of HIV transmission, spontaneous abortion, stillbirth, and multi-system disease in congenitally acquired infections, etc.

The persistence of syphilis in parts of the U.S., an industrialized nation with one of the best

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Epidemiology

Lyme Disease in MA: Surveillance Update

Lyme disease is the most commonly reported vectorborne disease in Massachusetts, accounting for more than 93% of all reported vectorborne cases. The Massachusetts Department of Public Health (MDPH) has been conducting passive Lyme disease surveillance since 1985. In addition to passive surveillance, in May 1999, MDPH implemented an active surveillance system involving eight regions around the state. Providers in each of these regions were identified, recruited, provided one-on-one education on Lyme disease, and then contacted on a bi-monthly basis to collect Lyme disease case reports. With assistance from local boards of health, MDPH successfully recruited 34 provider sites into the active surveillance program. The table summarizes preliminary surveillance data for Massachusetts by county for 1999. All but three counties (Suffolk, Worcester and Franklin) had annual incidence rates at or well above the national mean rate of 5.5 cases per 100,000 population.

During the upcoming Lyme disease season, MDPH will encourage all providers and boards of health to report all cases of Lyme disease, recruit additional providers within the active surveillance regions, and potentially add new regions. We anticipate that increased surveillance efforts will lead to more accurate disease reporting and a better understanding of the distribution and burden of Lyme disease in Massachusetts.

Lyme Disease Incidence Rates in Massachusetts by County, 1999**		
County	Number of Confirmed Cases	Incidence Rate Per 100,000
Barnstable*	111	54.1
Berkshire	28	20.9
Bristol	52	9.9
Dukes*	37	283.9
Essex	118	17.3
Franklin	0	0.0
Hampden	48	10.5
Hampshire	27	17.3
Middlesex	81	56.6
Nantucket*	68	103.2
Norfolk	55	8.8
Plymouth*	92	20.1
Suffolk	15	2.2
Worcester	32	4.3
State Total	764	12.3

* County populations during Lyme disease season (i.e. summer) is much higher than in other seasons, therefore incidence rates based on actual population at risk would be lower.

** Preliminary surveillance data (Updated 4/2000).

The Massachusetts Health Alert Network

With the advent of cheaper and more sophisticated information technology, the ability to connect key public health agencies into one seamless integrated communications and data exchange system now exists. A key effort will be the Health Alert Network, a web-based cross-jurisdiction communication and data-sharing system. The Internet serves as a cross-platform infrastructure that allows multiple computer applications and data streams to flow quickly and cheaply between any connected individual or agency. The Health Alert Network will also be used for online training of state and local personnel involved in public health response. It will address needs for rapid bi-directional communication between agencies and local health capacity building.

For further information on this initiative contact Tim Broadbent, MPA at (617) 983-6800 or via email at timothy.broadbent@state.ma.us.

Eliminating Syphilis

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health care systems in the world, is a sentinel public health event. Many communities at risk are communities of color, with African-American communities disproportionately affected.

Elimination of syphilis would be a landmark achievement because it would directly improve the health of many Americans and address a glaring racial disparity in health. It would also provide a symbolic redress of the legacy of the Tuskegee Study and neglect of rigorous measures to address syphilis. It will require that we build (or rebuild) basic public health capacity to control infectious diseases and ensure reproductive health.

The Centers for Disease Control and Prevention (CDC), with the assistance of professional, academic, and community advisors, issued The National Plan to Eliminate Syphilis in the United States. The goal is to reduce the number of primary and secondary syphilis cases to less than 1000 per year by 2003. Strengthened infrastructure to recognize and investigate cases, can ensure that transmission does not occur beyond initial cases. There are two cross-cutting strategies: 1) enhanced surveillance; and 2) strengthened community involvement and partnership. This second strategy was missing in the first two National Plans, formulated in 1936 and then again in 1961. Specific intervention efforts include 1) rapid outbreak response; 2) expanded clinical and laboratory services; and 3) enhanced health promotion.

In Massachusetts, the Division of STD Prevention has responded to the plan with several steps. All intervention strategies and policies will be reviewed. Gaps in surveillance will be identified and fixed. Progress on every syphilis investigation will be monitored. Syphilis serology screening will be enhanced in the jails and other sites where higher risk people might be found. The number of tests performed at the Suffolk County Jail has already increased. Finally, the Medical Foundation will convene and staff a multi-disciplinary Syphilis Elimination Advisory Group that will advise the Division and allies on strategies and progress. Affected communities will have direct involvement in policies and elimination activities, particularly in the health promotion arena.

1999 STD Summary

Sexually transmitted diseases (STD) continue to be a problem despite progress in prevention and control. There was a 36% decline in the number of cases of infectious syphilis reported in 1999 (97) compared to 1998 (150). This historically low number is an indication of the possibility of eliminating syphilis in Massachusetts within the next few years (see companion piece in this issue). However, the number of cases of gonorrhea increased from 2258 in 1998 to 2487 in 1999. This 10% increase was driven by an increase in the number of cases among teens and young adults.

Case interview data reveal an association with drug use as a common factor in many of these cases. Also, Massachusetts had a 7% increase in the reported number of cases of chlamydia in 1999 (8926) compared to 1998 (8363). This is partially the result of intensified efforts to offer screening to people who would ordinarily not have access to medical care or laboratory services.

The Division of STD Prevention and the State Laboratory's STD Laboratory, with increased federal funding, extended screening to two more jails, several Department of Youth Service lock-up facilities, and two HIV multi-service centers. Being able to test more effectively for an infection that most often occurs without symptoms allows infections to be diagnosed early, before more damaging and difficult to treat complications occur.

STD Trends in Massachusetts, 1990-1999

Disease	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Inf. Syphilis	1175	1013	700	440	278	223	262	187	150	97
Congenital Syphilis	14	5	6	6	6	2	7	1	6	1
Gonorrhea	7531	5984	3580	3099	3156	2658	2163	2077	2258	2487
Chlamydia	12251	10891	9804	8333	8049	7402	6791	7330	8363	8926
Pelvic Inflammatory Disease (total)	702	623	504	486	468	318	204	166	198	281
Chancroid	27	2	13	2	1	7	2	4	0	1

Refugee Admissions FY2000

The U.S. considers for admission as refugees, persons of special humanitarian concern who can establish persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group or political opinion. The Refugee Admissions Program for FY2000 has a ceiling of 90,000 admissions distributed regionally. The largest numbers are allocated to Europe (37,000), including the Former Yugoslavia, Kosovo and Former Soviet Union. The African ceiling has increased to 18,000. Ceilings in other regions are E. Asia (8,000), Near East/S. Asia (8,000) and Latin America/Caribbean (3,000), with an additional 6,000 as an unallocated reserve. Complete information is available at the Department of State website - www.state.gov/www/global/prm/prm_update.html. Approximately 3% of the refugees admitted to the U.S. have resettled in Massachusetts.

Immunization

MIP Honors Sites for Reaching Year 2000 Goal!

The Massachusetts Immunization Program (MIP) has been conducting practice-based assessments since 1993. Over the last seven years the MIP has honored 69 practices for reaching the Healthy People 2000 goal for immunization levels at or above 90% for their two-year-old patients. Recent National Immunization Survey results indicate that Massachusetts continues to have one of the highest immunization levels in the nation at 89%. Congratulations to the following practices for achieving the HP 2000 goal:

- Pushpa Agarwal, MD
- Bass River Associates
- Bowdoin Street Health Center
- Cambridge Pediatrics
- Cape Cod Pediatrics
- Child Health Associates-Auburn
- Chestnut Hill Pediatrics
- Coastal Primary Care, PC
- Community Health Center of Franklin County
- Concord Hillside Medical Associates
- Brian Dempsey, MD
- Dowd Medical Associates
- East Boston Neighborhood Health Center
- East Cambridge Health Center
- Ell Pond Medical Associates-Melrose
- Family Care of Tewksbury
- Rhonda S. Fogle, MD
- Franciscan Children's Hospital & Rehabilitation Center
- Garden City Pediatric Associates, Inc.
- Geiger-Gibson Community Health Center
- John H. Gould, MD
- Laurie Grauel, MD
- Greater Roslindale Medical & Dental Center
- Hanover Pediatrics, PC
- Harvard Vanguard Medical Associates-Cambridge
- Healthcare South Pediatrics-Hanover
- Healthcare South/Scituate Pediatrics
- Robert Hertzog, MD, Michael Gerrity, MD, Amy Griffin, MD
- Holden Pediatrics
- Holyoke Pediatric Associates, LLP
- James Hoyer, MD, Kelly Hoyer, MD
- Richard J. Kerbel, MD
- Lexington Pediatrics, PC
- Liberty Tree Pediatrics-Danvers
- Little House Health Center
- Macony Pediatrics
- Manet Community Health Center-Houghs Neck
- Manet Community Health Center-Snug Harbor
- Manet Community Health Center-North Quincy
- Anders Martenson, III, MD
- Medical Associates-Leominster
- Medical West Associates-Chicopee
- Medical West Associates-Springfield
- Merrimack Valley Pediatric Associates-Billerica
- Middleboro Pediatrics
- Burt E. Minaker, MD
- Patricia Moffatt, MD
- Leo R. Muido, MD
- Walter J. Murphy, Jr., MD
- North Shore Pediatrics-Beverly
- Pediatric Associates at Northwoods
- Pediatric Associates of Greater Salem
- Pediatric Associates of Norwood
- Pediatric Professional Associates, PC-Methuen
- Pediatric Services of Springfield, Inc.
- Joseph Smith Community Health Center
- South County Pediatrics-Webster
- South Cove Community Health Center
- South End Community Health Center
- South Shore Pediatrics-Weymouth
- Sumner Pediatrics, PC-Springfield
- The Neponset Health Center
- Tri-County Pediatric Associates-Stoughton
- Union Square Family Health
- George F. Viteck, MD, John Kelley, MD, Katherine Eisenmenger, MD
- Walpole Pediatric Associates, PC
- Western Massachusetts Pediatrics-Holyoke
- Woburn Pediatric Associates
- Worthington Health Center of Hilltown Community Health Centers, Inc.

New Immunization Guidelines Now Available

The Massachusetts Immunization Program (MIP) announces that three new guidelines are now available.

- Adult Immunization Guidelines
- Childhood Immunization Guidelines
- Guidelines for Vaccine Administration

Although the Childhood Immunization Guidelines have been issued each year, this is the first year that adult and general vaccine administration guidelines (which provide a general guide to site, route and spacing of vaccinations) have been issued. The guidelines are available on the DPH website at www.state.ma.us/dph or through the MIP regional offices.

Plan Now for the 2000-2001 flu season!

The Advisory Committee on Immunization Practices (ACIP) recently recommended that **everyone 50 years of age and older receive an annual influenza vaccination**. This will result in increased demand for flu vaccine next fall.

The Massachusetts Department of Public Health will purchase 730,000 doses of influenza vaccine, 45,000 more than last season. As in previous years, however, **state-supplied vaccine will not be sufficient to meet all the demand for flu vaccine**. All providers are urged to plan now for the next flu season:

- § **Take into account the new addition of everyone 50-64 years of age** when determining your need for flu vaccine. State-supplied vaccine for adults is prioritized for high-risk adults attending public clinics or residing in long-term care facilities. State-supplied vaccine for adults seen by private providers will be limited.
- § **Plan to purchase additional doses of influenza vaccine** if you will need more vaccine than you received from the Massachusetts Immunization Program (MIP) last year. Submit your orders for flu vaccine to your usual pharmaceutical distributor or to the following manufacturers as soon as possible:

Aventis Pasteur	1-800-822-2463
Wyeth-Lederle	1-800-358-7443

Private providers and local health departments are encouraged to collaborate on coordinat-

You be the epi

You are the public health nurse (PHN) and TB case manager in a large town. You receive a phone call from the local hospital informing you of a discharge, that day, of a "suspect" TB patient. The patient, a 16 year-old male, was admitted to the hospital with complaints of night sweats, fever and cough. He had been treated for pneumonia three months ago. Sputum smears are highly positive for acid fast bacilli, there is 17 mm induration on a PPD skin test and he has an abnormal CXR showing pneumonia and a right lower lobe cavity. Four anti-tuberculosis drugs were started three days ago. How do you prevent further transmission? What should be included in this discharge plan (from hospital to community) that will ensure the community is not put at-risk. How do you conduct the contact investigation for this patient?

Analysis

Discharge Plan:

Hospital discharge planning should begin upon admission of a patient with suspected or confirmed tuberculosis. At least two weeks of appropriate and effective treatment, usually four drugs and three consecutive negative sputum smears with symptom reduction would ensure that the patient is no longer infectious. Since this patient has had three days of treatment, the patient cannot be discharged (105 CMR365.600) until an appropriate discharge plan has been developed in cooperation with the hospital case manager and local PHN and TB case manager. This plan should include:

1. A pre-discharge home visit by the local PHN to evaluate the home environment. A potentially infectious patient cannot be discharged unless the home environment is safe with no household contacts with a high-risk of progressing to TB disease, e.g., infants or immunocompromised persons.
2. Evaluation of the patient to identify potential risks for non-adherence to treatment
3. Interventions for appropriate medical, nursing, and community follow up

Contact investigations should include the determination of the:

1. Infectiousness of the case
2. Duration and frequency of exposure and risk of transmission to others
3. Environmental characteristics – Are conditions crowded and conducive to transmission?
4. Susceptibility of the contacts – Are they at greater risk of progressing to disease?

With a hospitalized, potentially infectious patient, the initiation of the contact investigation should begin at the same time as the initial case assessment and continue upon discharge. Careful interview of the suspect and his family, on more than one occasion, may identify potential close contacts and exposure locations. Arrange for a bilingual/bicultural Outreach Educator, if necessary, to visit the family and friends to help in iden-

tifying close contacts and to address issues and concerns. Consultation with the TSA Nurse is recommended.

The contact investigation should include:

1. Screening close contacts (individuals who have shared air with the patient for a prolonged period of time) in the following categories – household, school/work and social.
2. Contacts with positive TB skin tests (documented converters) should be evaluated and treated for latent TB infection.
3. When there is evidence of transmission (documented converters) among the close contacts, screening should be expanded to include less close and more casual contacts.

Interviews with this patient as well as a review of his medical chart indicate that the patient has been symptomatic since late summer. In careful consideration of the characteristics and activities of this patient (adolescent, high school student) it was noted that prolonged exposure might have occurred among his classmates and/or close friends, and thus, the risk of transmission is high among this group.

Initial screening of close contacts

Household contacts

1. Test all people living in the patient's residence.
2. The results were: three of the five family members were PPD positive and did not recall being positive in the past
3. Refer those with a positive skin test for a CXR and medical evaluation
4. Repeat the skin test for the two family members who are initially skin test negative, 8-12 weeks post-exposure, as it can take that long for a vigorous immune response.

Close social/work/school contacts

1. Determine if there are contacts outside the immediate household, e.g., part-time job, volunteer activities or team sports.
2. Determine if other students, teachers, friends, coworkers need to be screened.

Contact investigation expanded to include casual contacts after evidence of conversion

*The three documented converters among the household contacts show there is evidence of recent transmission and the investigation should be expanded beyond the immediate household.



Refugee and Immigrant Health

Summary of Refugee Health Statistics, 1999

During 1999, Massachusetts received 2361 newly arrived refugees from 22 countries, including parts of the former Yugoslavia (923, mainly Bosnia and Kosovo) and Soviet Union (770, mainly Russia and Ukraine). Other countries were Vietnam (256), Somalia (131), Cuba (58), Liberia (57), and Haiti (53). Refugees undergo two health screenings during their migration process. The first occurs overseas and the second, within 90 days of arrival in the U.S.

The overseas evaluation is designed to identify health conditions that may pose a threat to the public health of the U.S. It targets specific communicable diseases, mental illness associated with violent behavior, and substance abuse. Significant findings are categorized as Class A (excludable) or Class B (a significant disease, defect, or disability which will require follow-up in the U.S.) Among Massachusetts arrivals rates of Class A and B conditions varied widely by region/country of origin (See Table 1).

In Massachusetts, refugees undergo screening at clinical sites with MDPH Refugee Health Assessment Program contracts. Clinicians perform a comprehensive medical history and physical examination, administer needed vaccines, and complete screening tests, including complete blood counts, urinalysis, hepatitis B serology, blood lead level, stool microscopy for ova and parasites, and a PPD tuberculin skin test. Clinicians also perform a visual inspection of dentition and gross assessment of hearing and visual acuity. The two most common medical conditions detected through screening were latent tuberculosis (TB) infection (50% of all tested with positive PPD skin test and dental caries (45% of all screened). Prevalence rates of intestinal parasites and anemia varied widely by regional/national origin. See Table 2.

Among 1801 refugees who presented a single stool specimen, microscopy revealed 809 parasites in 517 stools (29% of all tested). Of the parasites detected, 288 (36%) were pathogenic strains. Among the

pathogenic parasites detected most frequently, helminths included *Ascaris* (5%), *Trichuris* (33%), hookworm (5%), and dwarf tapeworm [*Hymenolepis*] (2%). Protozoans included *Entamoeba histolytica* (9%) and *Giardia lamblia* (45%). Helminth infections tended to be concentrated among refugees from Asia and Africa. Protozoans were more evenly distributed, including among refugees from the temperate Eastern European and former Soviet countries.

Anemia was more highly prevalent among Africans, particularly young children. This is most likely due to both significant undernutrition, with iron deficiency and hemolytic diseases such as malaria. Of note, however, are high rates of anemia also seen among children from the former Soviet Union. While African children more commonly have had evidence of growth failure (13% height-for-age and 8% weight-for-height), the former Soviet children tend toward overweight. When coupled with their high rates of anemia, a pattern of abnormal growth and nutrition similar to that of low-income U.S. children emerges.

Based on exam and historical findings, cli-

nicians diagnosed an additional 1244 medical conditions, which were not previously identified during the overseas examination, clustered in 36% of 2028 refugees who completed the assessment. Significant morbidity was found due to cardiovascular disease (19% of diagnoses; 12% of refugees), anemia (13% of diagnoses; 12% of refugees), genitourinary abnormalities (11% of diagnoses; 7% of refugees), and dermatologic diseases (10% of diagnoses; 6% of refugees).

While refugees come to the U.S. with significant health problems, most are treatable and short term. The Refugee Health Assessment promotes rapid access to health care services and the transition into on-going primary care for preventive care and follow-up of both acute and chronic conditions diagnosed during the health assessment process.

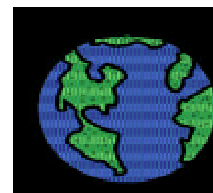


Table 1: Class A & A Conditions	Africa	Americas	Asia	Nr. East	Fmr USSR	Fmr Yugo	Total
TB-Related Conditions	8	0	43	0	44	33	128
Total # Conditions	109	3	52	3	503	138	805
# Refugees w/ Conditions	69	3	51	1	206	100	430
Total # Refugees	231	116	277	43	770	924	2361
Rate/1000 Refugees	472	26	188	70	653	149	341

Table 2: Health Conditions on Arrival	Africa	Americas	Asia	Nr. East	Fmr USSR	Fmr Yugo	Total
# Assessments	154	77	216	17	695	869	2028
+ PPD	51%	43%	40%	47%	45%	58%	50%
+ HBsAg	15%	0%	12%	0%	3%	1%	4%
+ O & P (any)	38%	58%	37%	59%	13%	34%	29%
Anemia	32%	18%	6%	0%	10%	11%	12%
Dental Disease	41%	27%	36%	47%	40%	54%	45%

New Guidelines on Targeted Testing and Treatment of Latent TB Infection

"Preventive treatment" or "isoniazid (INH) prophylaxis" were the terms commonly used in the past to refer to the practice of treating certain PPD skin test positive individuals, who had no evidence of active tuberculosis, to prevent future reactivation. Evolving strategies for TB control and elimination foresee a larger role for what is now called "targeted testing and treatment of latent TB infection."

In April, 2000, the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC) published as a supplement (in *The American Journal of Respiratory and Critical Care Medicine* 2000; 161(No. 4, part 2:S221-247)) new guidelines for targeted testing and treatment of latent TB infection. In addition to greater emphasis on treating latent infection, the new guidelines include other important changes from prior official recommendations. The following are annotated highlights. (For drug dosages and other details, readers are referred to the published guidelines):

- A greater role for primary care providers in testing and treating latent TB infection.
- *Targeted testing* of high-risk persons rather than *general screening* of all persons. However, determining who is at high enough risk to test should be based on local epidemiologic data, i.e., where are the cases in your area coming from? Testing of persons not at high risk for TB is discouraged due to the poor predictive value of the tuberculin skin test under those circumstances. In low-risk populations, many persons testing 10 to 12 mm will not have TB infection.
- *Testing* for latent infection to be linked to *treatment*. *If you would not treat, do not test.*
- Changes in the recommended treatment regimens to make them both more effective and safer for a wider range of patients. There are now 4 recommended treatment regimens, two of which are based on rifampin rather than INH (see below).
- *Clinical monitoring* of treatment by symptom checks at least monthly (rather than routine laboratory monitoring) is recommended for most patients, with certain exceptions detailed in the guidelines.
- Guidelines for *HIV-positive patients* have been published (MMWR 10/30/98; 47:RR-20) and recently up-

dated (MMWR 3/10/2000; 49:185-189). These include recommendations for minimizing interactions of the rifamycins with protease inhibitors or nonnucleoside reverse transcriptase inhibitors.

Changes in recommended treatment regimens:

- On the basis of greater efficacy, the optimal treatment duration for *INH* is now considered *9 rather than 6 months* for adult, pediatric, HIV-positive and HIV-negative persons, and persons with abnormal chest x-rays consistent with old TB. Although INH has always been recommended for high-risk persons *at any age*, non-INH (rifampin-based) regimens, less likely to cause hepatitis, can now be considered. (see below).
- 2 months *rifampin and pyrazinamide (PZA)* is recommended as an alternative regimen to 9 months of INH. Because INH is not included, concern about age-related hepatitis is greatly reduced. This regimen and a rifampin-only regimen of 4 months duration may be preferable for patients over age 35. However, rifampin accelerates the metabolism of many other drugs, including coumadin, methadone and birth control pills. Drug interactions may be a relative contraindication to using rifampin in some patients and may

Northeast regional TB update

Tuberculosis Surveillance Area (TSA) 3
TSA Nurse: Nancy Taylor Flynn, RN, BSN

Epidemiology: In 1999, there were 60 verified TB cases in TSA 3.

Clinical Services: TSA 3 is comprised of communities in Essex County and a portion of Middlesex County. There are four TB clinics located at the following hospitals: Saints Memorial Medical Center in Lowell, Lawrence General Hospital in Lawrence, Malden Medical Center in Malden and Salem Hospital in Salem. Physicians and Health Department/VNA nurses staff these clinics. A listing of the names and referral numbers of the clinics can be obtained from the Tewksbury Regional Health Office at (978) 851-7261.

Higher risk communities in TSA 3 include the following: Lawrence, Lowell, Lynn, and Malden. The TSA nurse assigns community outreach educators to these high-risk communities on a priority basis. They provide many diversified services and are a great asset to the Division of TB Prevention and Control. Services may include but are not limited to medication monitoring, documentation of patient encounters, adherence checks (e.g. pill counts etc.), sputum collection and health education. The following education programs are provided: Mantoux testing and interpretation (lecture and demonstration), TB 101, TB Update, and others as requested.

TB Community Prevention Project: The Division of TB Prevention and Control has initiated a community-based TB prevention project in Malden. The project focuses on TB prevention in the Chinese community. Wendy Eng has been hired as the part-time Chinese Health Liaison at Healthy Malden 2000. Wendy speaks both Mandarin and Cantonese and is a welcome addition to the Community-Based Prevention Project.

CD UPDATE

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Pandemic Flu Planning

July 13, 2000: CDC/NIP Satellite Course. For more information, contact Walt LaSota at (617) 983-6834.

Response to Bioterrorism

The Alabama Department of Public Health is offering a three-part satellite conference on their state's response to bioterrorism. All satellite conferences are from 1:30 - 3:30 Central Time.

May 25, 2000: The Environmental Impact

July 27, 2000: Public Health & Hospitals Working Together

September 12, 2000: What Is Your Role?

For more information fax Darlene Ruffin at (334) 206-5640 or register online at www.alapubhelath.org/alphn.

Immunization Update 2000

September 14, 2000, 9:00 - 11:00 AM.

This satellite broadcast will provide the most current information available in the constantly-changing field of immunization, especially information on new vaccines and new immunization requirements. It also emphasizes routine immunizations and standard immunization practices. For more information contact Walt LaSota at (617) 983-6834.

Northeast Regional TB Update

September 28, 2000. Location and time TBA. For more information, contact the Division of TB Prevention and Control at (617) 983-6970.

New Guidelines for TB Infection, continued from page 7

require dosage adjustments in the other agents, i.e., protease inhibitors and rifamycins.

- *Six months INH* is still considered an acceptable (but less effective) treatment duration for HIV-negative adults with normal chest x-rays who are unwilling or unable to take 9 months of INH. In addition, some providers may conclude that the 6-month INH treatment is the preferred duration for their patient population.
- Four months of *rifampin alone* is suggested as an alternative for patients unable to take INH or PZA.

It is likely that the use of these new guidelines will significantly change the treatment of latent TB infection in Massachusetts. As questions arise, please call Dr. Nardell at (617) 983-6970, or (617) 665-1029.

COMMUNICABLE DISEASE UPDATE is a free quarterly publication of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health, Howard K. Koh, Commissioner.

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